Health History

Patient name:	Date:
Date of Birth:	Email:
Address:	City/State/Zip:
Driver's License #	State issued:
Sex: $\Box M \Box F \Box Married \Box Single$	☐ Divorced ☐ Widowed ☐ Separated
Occupation:	Employer:
Spouses Name:	Spouses occupation:
Children:	
Who may we thank for referring you?	
Phone number: Cell	Home
Emergency Contact:	Phone #
Relationship to patient:	
Reason for visit:	
Is this due to an accident? \Box Yes \Box No \Box If yes, what \Box	
Has it been reported to: ☐ Insurance company	☐ Employer ☐ Work Comp
When did the symptoms appear?	Is the condition getting worse? \Box Yes \Box No
How often do you have this pain?	
Does it interfere with: ☐ Work ☐ Sleep ☐ Recreation	
Are the following painful or difficult?	ng □ Walking □ Lying □ Bending □ Lifting
□ Other Usin	ng the drawing below, where do you feel the pain?
Rate your pain from 1-10	
Do you feel the following?:	
□ Numbness □ Tingling □ Weakness	
☐ Sharp ☐ Dull ☐ Ache ☐ Throbbing	The state of the s
☐ Burning ☐ Swelling ☐ Stiffness ☐ Cramps	
How does your condition make you feel?	
What would you be able to do/enjoy that you can't currently i	f this condition was gone?
Have you been treated for this condition previously? \Box Ye	es \square No If yes, please check all that apply:
☐ Medication ☐ Surgery ☐ Chiropractic ☐ Nutri	ition Acupuncture Other
	rk Urine
X-Rays MRI/CT/U	Jltrasound

Mononucleosis Yes No Multiple Sclerosis Yes No Osteoporosis Yes No Pacemaker Yes No Parkinson's Yes No Pinched nerve Yes No Pneumonia Yes No Prostate problem Yes No Polio Yes No Prosthesis Yes No Psychiatric care Yes No Scarlet fever Yes No Rheumatoid Yes No Rheumatic fever Yes No Stroke Yes No Arthritis Suicide attempt Yes No Tonsillitis Yes No Thyroid Problem Yes No Tuberculosis Yes No Tumors Yes No Typhoid fever Yes No Ulcers Yes No Vaginal Yes No Yes No Ulcers Yes No Infections Yes No Other: Do you get headaches? Yes No How often? How would you describe them? Migraine Visual disturbance Nausea Tension Vomiting Aura Light sensitive Related to allergies Ocular migraine Are you pregnant? Yes No Are you taking birth control? Yes No Have you used hormone replacement? Yes No Are you taking birth control? Yes No No No No No No No N	AIDS	\square Yes \square No	Alcoholism	\square Yes \square No	Allergy shots		No	
Bleeding disorder	Anemia	\square Yes \square No	Anorexia	\square Yes \square No	Appendicitis	\square Yes \square No		
Bronchitis	Arthritis	\square Yes \square No	Asthma	\square Yes \square No	Autoimmune	\square Yes \square No		
Yes No	Bleeding disorder	\square Yes \square No	↑ Blood pressure	\square Yes \square No	Breast lump	\square Yes \square No		
Diabetes	Bronchitis	\square Yes \square No	Bulimia	\square Yes \square No	Cancer	\square Yes \square No		
Epilepsy	Cataracts	\square Yes \square No	Chemical	\square Yes \square No	Chicken pox	\square Yes \square No		
Gout	Diabetes	\square Yes \square No	Dependency		Emphysema		No	
Hemia	Epilepsy	\square Yes \square No	Glaucoma	\square Yes \square No	Goiter	\square Yes \square No		
High Cholesterol Yes No Kidney Disease Yes No Mumps Yes No Measles Yes No Miscarriage Yes No Mumps Yes No Mononucleosis Yes No Multiple Sclerosis Yes No Pacemaker Yes No Parkinson's Yes No Pinched nerve Yes No Pneumonia Yes No Prostate problem Yes No Polio Yes No Prosthesis Yes No Psychiatric care Yes No Scarlet fever Yes No Arthritis Suicide attempt Yes No Tomsillitis Yes No Thyroid Problem Yes No Tuberculosis Yes No Tumors Yes No Typhoid fever Yes No Ulcers Yes No Unfections Yes No The Ves	Gout	\square Yes \square No	Heart Disease	\square Yes \square No	Hepatitis	\square Yes \square No		
Measles Yes No Miscarriage Yes No Mumps Yes No Mononucleosis Yes No Multiple Sclerosis Yes No Osteoporosis Yes No Pacemaker Yes No Parkinson's Yes No Pinched nerve Yes No Pneumonia Yes No Prostate problem Yes No Polio Yes No Prosthesis Yes No Psychiatric care Yes No Scarlet fever Yes No Rheumatoid Yes No Rheumatic fever Yes No Tossillitis Yes No Arthritis Yes No Tuberculosis Yes No Tomoris Yes No Thyroid Problem Yes No Tuberculosis Yes No Tumors Yes No Typhoid fever Yes No Ulcers Yes No Infections Other: Do you get headaches? Yes No Yes No No How would you describe them? Migraine Visual disturbance Nausea Tension Vomiting Vericolate No Have you pregnant? Yes No No Are you taking birth control? Yes	Hernia	\square Yes \square No	Herniated Disc	\square Yes \square No	Herpes	\square Yes \square No		
Mononucleosis	High Cholesterol	\square Yes \square No	Kidney Disease	\square Yes \square No	Liver Disease	\square Yes \square No		
Pacemaker	Measles	\square Yes \square No	Miscarriage	\square Yes \square No	Mumps	\square Yes \square No		
Pneumonia Yes No Prostate problem Yes No Polio Yes No Prosthesis Yes No Psychiatric care Yes No Scarlet fever Yes No Rheumatoid Yes No Rheumatic fever Yes No Stroke Yes No Arthritis Suicide attempt Yes No Tonsillitis Yes No Thyroid Problem Yes No Tuberculosis Yes No Tumors Yes No Typhoid fever Yes No Ulcers Yes No Vaginal Yes No Vaginal Yes No No Yes No Infections Yes No Infections Yes No Infections Yes No Yes Yes No Yes No Yes Yes No Yes No Yes	Mononucleosis	\square Yes \square No	Multiple Sclerosis	\square Yes \square No	Osteoporosis		No	
Prosthesis Yes No	Pacemaker	\square Yes \square No	Parkinson's	\square Yes \square No	Pinched nerve		No	
Rheumatoid Yes No Rheumatic fever Yes No Stroke Yes No Arthritis Suicide attempt Yes No Tonsillitis Yes No Thyroid Problem Yes No Tuberculosis Yes No Tumors Yes No Tumors Yes No Infections Yes No Yes No Infections Yes No Infections Yes No Yes No Yes No Yes No Yes No No Yes No Yes No No Yes No No Yes No Yes No Yes No No Yes No Yes No Yes No No Yes No Yes No Yes No No Yes No No Yes No Yes No Yes No No Yes No Yes No Yes No Yes No Yes No Yes No	Pneumonia	\square Yes \square No	Prostate problem	\square Yes \square No	Polio		No	
Arthritis Suicide attempt Yes No Tonsillitis Yes No Thyroid Problem Yes No Tuberculosis Yes No Tumors Yes No Typhoid fever Yes No Ulcers Yes No Vaginal Yes No Venereal disease Yes No Whooping cough Yes No Infections Other: Do you get headaches? Yes No How often?	Prosthesis	\square Yes \square No	Psychiatric care	\square Yes \square No	Scarlet fever	\square Yes \square	No	
Thyroid Problem	Rheumatoid	\square Yes \square No	Rheumatic fever	\square Yes \square No	Stroke		No	
Typhoid fever	Arthritis		Suicide attempt	\square Yes \square No	Tonsillitis		No	
Venereal disease	Thyroid Problem	\square Yes \square No	Tuberculosis	\square Yes \square No	Tumors		No	
Other: Do you get headaches?	Typhoid fever	\square Yes \square No	Ulcers	\square Yes \square No	Vaginal		No	
Do you get headaches?	Venereal disease	\square Yes \square No	Whooping cough	\square Yes \square No	Infections			
How would you describe them? Migraine Visual disturbance Nausea Tension Vomiting Aura Light sensitive Related to allergies Ocular migraine Are you pregnant? Yes No Due Date Have you ever taken antibiotics? Yes No Are you taking birth control? Yes No Have you used hormone replacement? Yes No Do you skip meals? Yes No Amount of sugar you eat? Low Moderate High Do you crave sugar? Yes No Do you smoke? How many years? How many times a day? , a week? Have you ever smoked? How many years? When did you quit? Falls Date Head injuries Date Broken Bones Date Auto Accidents Date Date Auto Accidents Date Auto Accidents Date Date Auto Accidents Auto Accident	Other:					_		
Are you pregnant?	Do you get headaches? \Box Yes \Box No			How often?				
Are you pregnant?	How would you desc	ribe them?	☐ Migraine ☐ Visual	l disturbance \Box	Nausea □ Tens	sion 🗆 V	omiting	
Have you ever taken antibiotics?			□ Aura □ Light sen	sitive Relate	ed to allergies	Ocular n	nigraine	
Have you used hormone replacement?	Are you pregnant?		\square Yes \square No	Due Date				
Are you Vegetarian?	Have you ever taken	antibiotics?	\square Yes \square No	Are you takin	g birth control?	\square Yes	\square No	
Amount of sugar you eat?	Have you used horme	one replacement?	\square Yes \square No					
Do you smoke? How many years? How many times a day?, a week? Have you ever smoked? How many years? When did you quit? Falls Date Head injuries Date Broken Bones Date Auto Accidents Date	Are you Vegetarian?		\square Yes \square No	Do you skip n	neals?	\square Yes	\square No	
Have you ever smoked? How many years? When did you quit? Date Date Broken Bones Date Auto Accidents Date	Amount of sugar you	eat? 🗆 Low	☐ Moderate ☐ High	Do you crave	sugar?	\square Yes	\square No	
FallsDateHead injuriesDateBroken BonesDateAuto AccidentsDate	Do you smoke?	How many yea	ars? H	ow many times a	day?, a	week?		
Head injuries Date Broken Bones Date Auto Accidents Date	Have you ever smoke	ed?	How many years? _		When did you q	uit?		
Head injuries Date Broken Bones Date Auto Accidents Date	Falls				Date			
Broken Bones Date Date Date Date Date Date Date Date								
Auto Accidents Date								

Any developmental delays for age? (ie., crawling, walking, talking, reading, etc.)
Any behavioral issues?
Any sleep issues? Yes / No – If yes, describe:
Any known reactions when/after given vaccinations?
Do parents have any known food allergies? \square Yes \square No – If yes, to
what:
Infant: Spitting Up \Box Yes \Box No – If so, how frequently?
Infant: On formula? \Box Yes \Box No $-$ If so, what
type?